"No Cooperation"

Two Simultaneous Outbreaks

Long Term Care Facility

- 98 bed licensed Medicaid certified long-term care facility
- The mission is to provide quality, efficient and economical services to residents of West Virginia who require long-term care and behavioral intervention in order to maximize their functioning ability and independence, enabling them to become successful and satisfied in their environment.

Outbreak Reported to Local Health Department

- January 13 called to report a Gastro-intestinal outbreak with 8 ill residents
- Local Public Health Nurse reported to Regional Epidemiologist and RE reported to Division of Infectious Disease Epidemiology
- Told LTCF to provide line list of outbreak and supply samples to OLS

Second Report

- Later that day on January 13, Infection Preventionist at local hospital reported to LHD that they had two requests from LTCF to test for influenza
- PH Nurse called LTCF and confirmed that samples were submitted from the facility for testing (and more patients are ill)
- A second outbreak report was generated to the RE and DIDE

1. Establishing the Existence of an Outbreak

- The first step in an outbreak investigation is to confirm the existence of an outbreak.
 - 8 ill in the facility is more than usual for any GI illness
 - At least two ill from influenza- like illness is an outbreak (if MORE are ill after looking)

2. Verifying the Diagnosis

- Review the patients' clinical findings/ histories and laboratory results.
- Obtain line lists and any laboratory tests that may be available
- Have the LHD assist the LTCF in sending specimens for testing.

3. Construct a Working Case Definition

-A GI outbreak is defined as onset of two or more epidemiologically linked cases within a three day period, where a case is defined as someone with 2 or more episodes of vomiting or three or more episodes of diarrhea within 24 hours.

-An influenza or influenza-like illness (ILI) outbreak is defined as three or more cases of influenza-like illness in a defined setting within a 3-day period (e.g., hospital unit, long term care facility, etc.).

4. Find Cases Systematically and Record Information

All information obtained should be placed into a line listing. A line listing allows information about time, person, and place to be viewed quickly. A line listing should include the patient's name, age, gender, date and time of symptom onset, symptoms experienced, lab tests conducted to confirm suspect diagnosis and their results, and space for additional comments.

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			Lin	Gender Gender (May May 1) Onto the time of the setting (May 1) Onto the											
Name	Date of Birth (mm/dd/yy)	Age	Room/Bed #										(ou/se/l) pelQ	Lab testing results	Date lab testing done
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Influenza Outbreak Line List

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lama of Outbrook:																
Name of Outbreak:																
ocal Health D						Contact / Phone:										
Name	Date of Birth (mm/dd/yy)	Age	Cabin / class / group	Gender	Onset date (mm/dd/yy)	(K.Kıppıu w)	Fever (yes/no)	Highest Temperature	24Bnoo	Sore throat?	# of Episodes of Diarrhea	Vomiting (yes/no)	Other Symptoms	Lab teeting	Case Status	Comments

AND THINGS WENT DOWN HILL FROM THERE!!!!!

- The LHD made calls that were not returned
 - Calls were made on January 14 and 15
- Initial line lists were submitted to the LHD on January 15 but were incomplete
 - GI line list showed outbreak began on January 10 but was reconstructed by LTCF (obvious forgery)
 - Showed 7 ill (not 8 as originally reported)
 - ILI line list showed 7 residents and 7 staff ill
 - Originally reported 2 ill residents (and no staff)

More Information was Needed

- 5 days of NO CONTACT- calls and emails daily
 - 5 phone messages and 5 e-mails
- DIDE intervened and called LTCF Director of Nursing- message left with NO RESPONSE
- Local Health Officer discussed situation with Director of Nursing with LIMITED RESPONSE-Agreed but did not follow through with requests

Regional Epidemiologist and LHD Nurse visited on January 23

- RE accompanied by Local Public Health Nurse- met with Director of Nursing and Infection Preventionist
- A difficult meeting transpired!
- Met in lunch room
- Listened to every medical problem that both of them had since birth
- ICP made the statement that she "never had and never would" take the flu shot

Visit (con't)

- DON explained to us that she really doesn't have control over staff and they are severely understaffed in the facility
 - Short 15 nurses and at least 30 aides
 - "So please, relax with my ICP, 'cause I don't want her to quit"

Promised to get LHD more information and line lists on 2 outbreaks

GI OUTBREAK-Results and Findings

- No other line lists were received from the facility on the GI outbreak
- No GI samples were taken so no test results were available
- No epi-curve could be developed
- No more contact with facility on this outbreak

ILI OUTBREAK-Results and Findings

- Line list obtained on February 6
 - Another "made up" line list with facts obviously not true and didn't match original line list
- Test results of the initial two samples were negative for Influenza A and B
- No epi-curve or timeline could be developed as 1st and 2nd line lists were not congruent (names, symptoms, dates, etc.)
- No other swabs were taken

Lessons Learned

- Sometimes your best efforts are to no avail
- Remember, the residents of the LTCF are who you are working for, not the staff
- Carefully read your line lists and reports as obvious forgeries shouldn't be considered
- Understaffing at a LTCF may be a problem but does not absolve the facility from responding to requests and following proper protocols

And "The Rest of the Story"

- Later in the spring the ICP and DON were replaced
- The LHD continues to have a good working relationship with the LTCF

QUESTIONS